DMERC Information Form: IMMUNOSUPPRESSIVE DRUGS

ALL INFORMATION ON THIS FORM MAY BE COMPLETED BY THE SUPPLIER

Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(___) _____ HICN _____	(___) _____ NSC # _____
PLACE OF SERVICE _____ NAME and ADDRESS of FACILITY if applicable (see reverse):	PT DOB ___/___/___ Sex _____ (M/F)

TRANSPLANT DIAGNOSIS CODES (ICD-9) (CIRCLE APPROPRIATE CODES): V42.1 (HEART); V42.7 (LIVER); V42.0 (KIDNEY); V42.6 (LUNG); V42.8 (BONE MARROW); V42.8 (OTHER-SPECIFY) (_____)

ANSWERS	ANSWER QUESTIONS 1 - 5 AND 8 - 12 FOR IMMUNOSUPPRESSIVE DRUGS (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, Unless Otherwise Noted)
	Questions 6 and 7, reserved for other or future use.
	What are the drug(s) prescribed and the dosage and frequency of administration of each? HCPCS MG TIMES PER DAY 1. _____ _____ _____ 2. _____ _____ _____ 3. _____ _____ _____
Y N	4. Has the patient had an organ transplant that was covered by Medicare?
Enter Correct Number(s) _____ _____ _____	5. Which organ(s) have been transplanted? (Use most recent transplant) (May enter up to three different organs). 1 - Heart 2 - Liver 3 - Kidney 4 - Bone Marrow 5 - Lung 6 - Whole organ pancreas, simultaneous with or subsequent to a kidney transplant 7 - Reserved future use 8 - Reserved future use 9 - Other
_____	8. Name of facility where transplant was performed.
_____	9. City where facility is located.
_____	10. State where facility is located.
___/___/___	11. On what date was the patient discharged from the hospital following this transplant surgery?
Y N	12. Was there a prior transplant failure of this same organ?

PHYSICIAN NAME, ADDRESS (Printed or Typed)	
UPIN: _____ **TELEPHONE #** _____	_____ ___/___/___ **SUPPLIER'S SIGNATURE** **DATE** (A Stamped Signature Is Not Acceptable) _____ **PRINT NAME**

Rev. 07/13/2000

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CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient indicate this by placing date (MM/DD/YY) needed initially in the space marked, "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patients changing clinical needs), indicate the initial date needed In the space marked, "INITIAL," and also indicate the effective date of the order change In the space marked, "REVISED."
PATIENT INFORMATION:	Indicate the patients name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on the his/her Medicare card and on the claim form.
SUPPLER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Suppler Clearinghouse (NSC).
PLACE OF SERVICE:	Indicate the place in which the drug is being used, i.e., patient's home Is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC suppiler manual for a complete list.
FACILITY NAME:	If the place of service is a facility, indicate the name and complete address of the facility
PATIENT DOB AND SEX:	Indicate patent's date of the (MM/DD/YY) and sex (male or female).
TRANSPLANT DIAGNOSIS CODES:	Circle the appropriate ICD-9 code reflecting the organ transplant for which this immunosuppressive drug is being prescribed. If an organ other than those listed was transplanted, circle V42.8 and print or type in the name of the organ in the parentheses.
QUESTION SECTION:	This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the drugs ordered, circling "Y" for yes, "N" for no, a number if this is offered as an answer option or fill in the blank, if other information is requested.
PHYSICIAN NAME, ADDRESS:	Indicate physician's name and complete mailing address.
UPIN:	Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).
PHYSICIAN'S TELEPHONE NO:	Indicate the telephone number where the physician can be contacted (preferably a number where records would be accessible pertaining ID this patient) If more information is needed.
SUPPLIER'S SIGNATURE:	The person who completed this form and accepts responsibility for the accuracy and completeness of the information contained on this form signs and dates this form. Signature and date stamps are not acceptable.
PRINTED NAME:	The Person signing the form, legibly prints or types his/her name.